First Health Services of Montana
ACUTE INPATIENT SERVICES
Authorization Request Form

First Health Services of Montana

To transmit request information:
FAX: 1-800-639-8982
PHONE: 1-800-770-3084

Mail: 4300 Cox Road
Glen Allen VA 23060

Acute Inpatient Admission (Medicaid only): Youth _____ Adult _____

Please print or type:

PATIENT INFORMATION		
Admit Date: / /	**Attending Physician:**	
Patient Name:		
Marital Status: single • married • separated • divorced •		
DOB: / /	**Gender: M • F •**	
Address:		
City:	**State:**	**Zip Code:**
Medicaid Number:	**SSN:**	
Is the patient in State custody? Yes • No •		
RESPONSIBLE PARTY INFORMATION (if other than patient)		
Name:		
Address:		
City:	**State:**	**Zip Code:**
Relationship to patient: self • parents • government agency • other relative •		
ADMITTING FACILITY INFORMATION		
Name:	**Provider Number:**	
Address:		
City:	**State:**	**Zip Code:**
Telephone Number:	**Fax Number:**	
Estimated Length of Stay:		
CLINICAL INFORMATION		
DSM IV DIAGNOSIS:		
Axis I	**Code**	**Narrative**
	Code	**Narrative**
	Code	**Narrative**
Axis II	**Code**	**Narrative**
Axis III		
Axis IV		
Axis V		
Reason for Admission: (description of symptoms/behavior that necessitate acute inpatient level of care)		

Processing may be delayed if information submitted is illegible or incomplete

Name Last: _____ First: _____
SSN: _____

Reason for Admission continued:
Mental Status:
Current Medication (include dosage and start date):
Treatment Plan/Goal:
Precautions: Suicide • Aggression • Elopement • Other •
Does the patient have any drug/alcohol issues? (Please describe substances used, frequency and amount)
Blood Alcohol Level (if done):
Urine Drug Screen (if done):
Vital Signs: BP: Temp: Pulse: Respirations:
Withdrawal Symptoms:
Does the patient have any legal issues? Yes • No • Please describe:
Previous Inpatient Treatment (please describe):

Processing may be delayed if information submitted is illegible or incomplete

Name Last: _____ First: _____
SSN: _____

Previous Outpatient Treatment (please describe):
Does the patient have a case manager? Yes • No •
Case Manager name:
Case Management company:
Discharge Plan (please include estimated date of discharge):
Assessment completed by:
Title: Date:

Certificate of Need required for Medicaid recipients under 21

For First Health's Use Only:
APPROVED**:** From_____ Thru_____ DENIED: From_____ Thru_____
Review Date:_____ Reviewer Signature: _____

Processing may be delayed if information submitted is illegible or incomplete